Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

_____
Date

MEDICAID REIMBURSEMENT WORKSHEET

_____
Name

_____
Street

_____
City/Zip

Client: _____

ID Number: _____

Date of Loss: _____

A. Gross Settlement Amount $ _____

B. Total Amount to be Recovered by Medicaid $ _____

C. Ratio (B ÷ A) %_____

D. Attorney's Fee $ _____ + Costs $ _____

= Total $ _____

E. Medicaid's Pro Rata Share of Costs (D x C) $ _____

F. Medicaid's Reimbursement (B – E) $ _____

Reimbursement Instructions:

Please prepare check(s) as specified below.

Payee on Check:

Department of Social and Health Services $ _____

Forward the checks to:

Division of Customer Support
COB Casualty Unit
P.O. Box 45561
Olympia, WA 98504-5561